Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL ORTHOPEDIC SURGICAL GROUP
2760 ATLANTIC AVE
LONG BEACH CA 90806

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-09-7806-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual has denied this claim twice. We have already sent an appeal with reconsideration for payment the insurance. We understand that when Texas Mutual informs us that we will need to send this claim to Medical Dispute. Our reasons for the dispute are for payments for procedure code 29877. This procedure was denied due to because it was a 'globalize with 29875 going by the NCCI with modifier not allowed'. Clearly, procedure 29875 is a distinct code; it has a modifier of 51 and 59 so therefore it should not be globalize claim with 29877 when it is a separate procedure perform."

Amount in Dispute: $1,637.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual offers to pay an additional $402.42 to settle this dispute. To get the MAR reimbursement for code 29877 an additional payment of $402.42 can be added to the mistaken payment made for code 29875. $670 was paid on 29875. When this amount is added to $402.42, the total amount is $1,072.42."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2008	CPT Code 29877	$1,637.00	$936.68

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203(b)(1) and (c)(1) sets out the Medicare payment policies and procedures for the Division of Workers' Compensation and it's system participants to calculate the MAR for professional services. System participants shall apply the Medicare payment policies with minimal modifications.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 27, 2008 and December 29, 2008:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 435 – Per NCCI Edits, the value of this procedure is included in the value of the comprehensive procedure.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 891 – The insurance company is reducing or denying payment fter reconsideration.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
3. Was the requestor reimbursed in accordance with 28 Texas Administrative Code §134.203 and is the requestor entitled to reimbursement?

Findings

1. The requestor provided surgical services in the state of California on March 3, 2088 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. The requestor submitted the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code 133.307.
3. Texas Workers Compensation system utilizes Medicare payment policies. In accordance with 134.203(b)(1), effective March 1, 2008, 33 TexReg 364, system participants shall apply Medicare payment policies, including its coding, billing, correct coding initiative (CCI) edits. Review of the submitted documentation finds that the Respondent did not reimburse the requestor according to the Medicare payment policies. CPT Code 29877 was the preauthorized, primary procedure for the surgical intervention performed on the injured employee; however, this code was denied by the respondent as being global to CPT Code 29875. According to CCI edits CPT Code 29877 is not global to any other code submitted on the CMS-1500 for the disputed date of service. Therefore, the denial code is not supported and reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ $936.68.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $936.68 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 9, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.